

**STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING AND INVESTIGATIONS SECTION**

IN RE: Maefair Health Care Center of Trumbull, CT d/b/a
 Maefair Health Care Center
 21 Maefair Court
 Trumbull, CT 06611

CONSENT ORDER

WHEREAS, Maefair Health Care Center of Trumbull, CT (hereinafter the "Licensee"), has been issued License No.2142-C to operate a Chronic and Convalescent Nursing Home known as Maefair Health Care Center, (hereinafter the "Facility") under Connecticut General Statutes 19a-490 by the Department of Public Health, State of Connecticut (hereinafter the "Department"); and

WHEREAS, the Facility Licensing and Investigations Section (hereinafter "FLIS") of the Department conducted unannounced inspections on various dates commencing on June 13, 2005 and concluding on June 27, 2005; and

WHEREAS, the Department, during the course of the aforementioned inspections identified violations of the Connecticut General Statutes and/or Regulations of Connecticut State Agencies in a violation letter dated July 20, 2005 (Exhibit A – copy attached); and

WHEREAS, the Licensee is willing to enter into this Consent Order and agrees to the conditions set forth herein.

NOW THEREFORE, the FLIS of the Department acting herein and through ^{Joan D. Leavitt}~~Marianne Horn~~, its ^{PHSM}~~Section Chief~~, and the Licensee, acting herein and through Lawrence Santilli, its Director, hereby stipulate and agree as follows:

1. The Licensee shall execute a contract with an Independent Nurse Consultant (INC) approved by the Department within two (2) weeks of the effective date of this Consent Order. The INC's duties shall be performed by a single individual unless otherwise approved by the Department.

2. The INC shall function in accordance with FLIS's INC Guidelines (Exhibit B – copy attached). The INC shall be a registered nurse who holds a current and unrestricted license in Connecticut. The Registered Nurse assuming the functions of the INC shall not be included in meeting the nurse staffing requirements of the Regulations of Connecticut State Agencies.
3. The INC shall provide consulting services for a minimum of two (2) months at the Facility unless the Department identifies through inspections that a longer time period is necessary to ensure substantial compliance with applicable federal and state statutes and regulations. The INC shall be at the Facility forty (40) hours per week and shall arrange his/her schedule in order to be present at the Facility at various times on all three shifts including holidays and weekends. The Department will evaluate the hours of the INC at the end of the two (2) month period and may, in its discretion, reduce or increase the hours of the INC and/or responsibilities, if the Department determines the reduction or increase is warranted. The terms of the contract executed with the INC shall include all pertinent provisions contained in this Consent Order.
4. The INC shall have a fiduciary responsibility to the Department.
5. The INC shall conduct and submit to the Department an initial assessment of the Licensee's regulatory compliance and identify areas requiring remediation within two (2) weeks after the contract is approved by the Department.
6. The INC shall confer with the Licensee's Administrator, Director of Nursing Services, and other staff determined by the INC to be necessary to the assessment of nursing services and the Licensee's compliance with federal and state statutes and regulations.
7. The INC shall make recommendations to the Licensee's Administrator, Director of Nursing Services and Medical Director for improvement in the delivery of direct resident care in the Facility. If the INC and the Licensee are unable to reach an agreement regarding the INC's recommendation(s), the Department, after meeting with the Licensee and the INC shall make a final determination, which shall be binding on the Licensee.

8. The INC shall submit weekly written reports to the Department documenting:
 - i. the INC's assessment of the care and services provided to residents;
 - ii. the Licensee's substantial compliance with applicable federal and state statutes and regulations; and
 - iii. any recommendations made by the INC and the Licensee's response to implementation of the recommendations.
9. Copies of all INC reports shall be simultaneously provided to the Director of Nurses, Administrator and Medical Director.
10. The INC shall have the responsibility for:
 - a. Assessing, monitoring, and evaluating the delivery of direct resident care with particular emphasis and focus on the delivery of nursing services by registered nurses, licensed practical nurses, nurse aides, and orderlies and implementing prompt training and/or remediation in any area in which a staff member demonstrated a deficit. Records of said training and/or remediation shall be maintained by the Licensee for review by the Department;
 - b. Assessing, monitoring, and evaluating the coordination of resident care and services delivered by the various health care professionals providing services;
 - c. Recommending to the Department an increase in the INC's contract hours if the INC is unable to fulfill the responsibilities within the stipulated hours per week; and
 - d. Monitoring the continued implementation of the Licensee's plan of correction submitted in response to the violation letter dated July 20, 2005 (Exhibit A).
11. The INC, the Licensee's Administrator, and the Director of Nursing Services shall meet with the Department every six (6) weeks for the first three (3) months after the effective date of this Consent Order and thereafter at eight (8) week intervals throughout the tenure of the INC. The meetings shall include discussions of issues related to the care and services provided by the Licensee and the Licensee's compliance with applicable federal and state statutes and regulations.

12. Any records maintained in accordance with any state or federal law or regulation or as required by this Consent Order shall be made available to the INC and the Department, upon request.
13. The Department shall retain the authority to extend the period the INC functions are required, should the Department determine that the Licensee is not able to maintain substantial compliance with federal and state laws and regulations. Examples of violations that may cause the Department to invoke this provision include, but are not limited to: failure to notify the physician of a significant change in condition; failure to provide care and treatment to residents identified with unstable health conditions; and/or failure to implement physician orders or plans of care. Determination of substantial compliance with federal and state laws and regulations will be based upon findings generated as the result of onsite inspections conducted by the Department.
14. The Director of Nursing Services and/or Assistant Director of Nursing Services shall conduct random unannounced visits at least three (3) times a week to the Facility to assess care and services being provided. Said visits shall occur on holidays, weekends, and shall include all three (3) shifts. Documentation of the assessment of care and services during these visits shall be maintained and available for Department review, upon request.
15. The Licensee shall immediately notify the Department if the position(s) of Administrator, Director of Nurses, Assistant Director of Nurses, Medical Director, the Infection Control Nurse, and/or MDS Coordinator become vacant due to resignations. In the event of a vacancy in any of these identified positions, the Administrator shall provide the Department with weekly reports pertaining to recruitment efforts until the position is refilled.
16. Effective upon the execution of this Consent Order, the Licensee, through its Governing Body, Administrator and Director of Nursing Services, shall ensure substantial compliance with the following:
 - a. Sufficient nursing personnel are available to meet the needs of the residents;
 - b. Residents are maintained, clean, comfortable and well groomed;

- c. Resident treatments, therapies and medications are administered as prescribed by the physician and in accordance with each resident's comprehensive care plan;
 - d. Resident assessments are performed in a timely manner and accurately reflect the condition of the resident;
 - e. Each resident care plan is reviewed and revised to reflect the individual resident's problems, needs and goals, based upon the resident assessment and in accordance with applicable federal and state laws and regulations;
 - f. Nurse aide assignments accurately reflect resident needs;
 - g. Each resident's nutritional and hydration needs are assessed and monitored in accordance with his/her individual needs and plan of care;
 - h. The personal physician or covering physician is notified in a timely manner of any significant changes in resident condition including, but not limited to, decline in skin integrity, presence of any infection, and deterioration of mental, physical, nutritional, and/or hydration status. In the event that the personal physician does not adequately respond to the resident's needs or if the resident requires immediate care, the Medical Director is notified;
 - i. Residents with pressure sores and/or impaired skin integrity are provided with the necessary care to treat and prevent pressure sores and/or impaired skin integrity. Wounds, including pressure sores, are monitored and assessed in accordance with current regulations and standards of practice;
 - j. Necessary supervision and assistive devices are provided to prevent accidents;
 - k. Policies and procedures related to dehydration prevention will be reviewed and revised to include, in part, notification of the attending physician or medical director when the resident's fluid intake does not meet their assessed needs; and
 - l. Resident injuries of unknown origin are thoroughly investigated, tracked, and monitored.
17. Effective upon the execution of this Consent Order, the Licensee shall appoint a free floating Registered Nurse Supervisor on each shift whose primary responsibility is the assessment of residents and the care provided by nursing staff. A nurse supervisor shall maintain a record of any resident related issue(s) or problem(s) identified on his or her

18. shift and a notation as to the subsequent action taken to resolve the problem(s). Such records shall be made available to the Department upon request and shall be retained for a three (3) year period.
19. Individuals appointed as Nurse Supervisor shall be employed by the facility. shall not carry a resident assignment and shall have previous experience in a supervisory role.
20. Nurse Supervisors shall be provided with the following:
 - a. A job description which clearly identifies the supervisor's day-to-day duties and responsibilities;
 - b. A training program which clearly delineates each Nurse Supervisor's responsibilities and duties with respect to resident and staff observations, interventions and staff remediation;
 - c. Nurse Supervisors shall be supervised (includes reasonable on-site supervising as described below) and monitored by a representative of the Licensee's Administrative Staff, (e.g. Director of Nursing Service or Assistant Director of Nursing Service) to ensure the Nurse Supervisors are functioning in accordance with this Consent Order and state and federal requirements. Said administrative supervising and oversight shall be provided on all three (3) shifts on an irregular schedule of visits. Records of such administrative visits and supervision shall be retained for the Department's review; and
 - d. Nurse Supervisors shall be responsible for ensuring that all care is provided to residents by all caregivers in accordance with individual comprehensive care plans.
21. The Licensee, within seven (7) days of the execution of this document, shall designate an individual within the Facility to monitor the requirements of this Consent Order. The name of the designated individual shall be provided to the Department within said timeframe.
22. The Licensee shall establish a Quality Assurance Program (QAP) to review resident care issues including those identified in the July 20, 2005 violation letter. The members of the QAP shall meet at least monthly to review and address the quality of care provided to residents and, if applicable, implement remediation measures. Membership shall at a minimum, include the Administrator, Director of Nurses, Infection Control Nurse, Nurse

Supervisors, and the Medical Director. Minutes of the QAP meetings shall be kept for a minimum of three (3) years and made available for review upon request of the Department.

23. The Licensee shall pay a monetary penalty to the Department in the amount of twenty-five thousand dollars (\$25,000.00), by money order or bank check payable to the Treasurer of the State of Connecticut and mailed to the Department within (2) weeks of the effective date of this Consent Order. The money penalty and any reports required by this document shall be directed to:

Rosella Crowley, R.N.,
Supervising Nurse Consultant
Facility Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue, P.O. Box 340308 MS #12HSR
Hartford, CT 06134-0308

24. The Licensee of Maefair Health Care Center of Trumbull, CT. known as Maefair Health Care Center is hereby censured.
25. All parties agree that this Consent Order is an Order of the Department with all of the rights and obligations pertaining thereto and attendant thereon. Nothing herein shall be construed as limiting the Department's available legal remedies against the Licensee for violations of the Consent Order or of any other statutory or regulatory requirements, which may be sought in lieu of or in addition to the methods of relief listed above, including all options for the issuance of citations, the imposition of civil penalties calculated and assessed in accordance with Section 19a-524 et seq. of the General Statutes, or any other administrative and judicial relief provided by law. This Consent Order may be admitted by the Department as evidence in any proceeding between the Department and the Licensee in which compliance with its terms is at issue. The Licensee retains all of its rights under applicable law.
26. The execution of this document has no bearing on any criminal liability without the written consent of the Director of the MFCU or the Bureau Chief of the Department of Criminal Justice's Statewide Prosecution Bureau.
27. The terms of this Consent Order shall remain in effect for a period of two (2) years from the effective date of this document unless otherwise specified in this document.

28. The Licensee had the opportunity to consult with an attorney prior to the execution of this Consent Order.

*

*

*

*

*

*

*

Licensee: Maefair Health Care Center of Trumbull, CT.

Page 9

WITNESS WHEREOF, the parties hereto have caused this Consent Order to be executed by their respective officers and officials, which Consent Order is to be effective as of the later of the two dates noted below.

10/11/05
Date

Maefair Health Care Center of Trumbull, CT
By: [Signature]
Lawrence Santilli, its Director

STATE OF Connecticut)

County of Hartford) ss Southington 10/11 2005

Personally appeared the above named Lawrence Santilli and made oath to the truth of the statements contained herein.

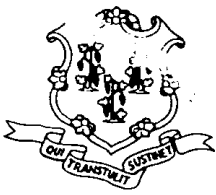
My Commission Expires: 12/31/05
(If Notary Public)

[Signature]
Notary Public ☒
Justice of the Peace ☐
Town Clerk ☐
Commissioner of the Superior Court ☐

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

10/13/05
Date

By: [Signature]
~~Marianna Horn, R.N., J.D., Section Chief~~
Joan D. Leavitt, PhD
Facility Licensing and Investigations Section



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

EXHIBIT A
PAGE 1 OF 36

July 20, 2005

Ms. Judith Konoval,
Maefair Health Care Center
21 Maefair Court
Trumbull, CT 06611

Dear Ms. Konoval:

Unannounced visits were made to Maefair Health Care Center on June 13, 14, 15, 16, 17, 22, 23 and 27, 2005 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations, and licensure and certification surveys.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the visits.

An office conference has been scheduled for August 2, 2005 at 10 AM in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut. Should you wish legal representation, please feel free to have an attorney accompany you to this meeting.

Please prepare a written Plan of Correction for the above mentioned violations to be presented at this conference.

Each violation must be addressed with a prospective Plan of Correction which includes the following components:

1. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, inservice program, repairs, etc.).
2. Date corrective measure will be effected.
3. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.

If there are any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

Rosella Crowley R.N.

Rosella Crowley, R.N.
Supervising Nurse Consultant
Facility Licensing and Investigations Section

SNC:NC:

- c. Director of Nurses
Medical Director
President
vl
complaint #CT-4073, 4032, 4091, 3743, 3671



Phone: (860) 509-7400
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12HSR
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer

FACILITY: Maefair Health Care Center

DATES OF VISIT: June 13, 14, 15, 16, 17, 22, 23 and 27, 2005

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-Dt8
(j) Director of Nurses (2)(L).

1. Based on clinical record review and interviews for 1 of 2 sampled residents with poor fluid intakes and the risk for dehydration (Resident #29), the facility failed to notify the resident's attending physician when the resident continuously failed to meet the minimum fluid intake needs. The findings include:
 - a. Resident #29 was admitted to the facility on 6/2/05 with diagnoses that included left shoulder fracture, dementia, dehydration and osteoarthritis. The hospital discharge summary of 6/2/05 identified that the resident had been admitted to the hospital from a different nursing home with "profound dehydration". A nursing admission assessment dated 6/2/05 identified that the resident required assistance for bed mobility and transfers, and was a total feed. The care plan dated 6/8/05 identified the potential for dehydration. The only intervention specific to dehydration was to monitor for signs and symptoms of dehydration. The resident's weight was noted as 130 pounds and fluid requirements were estimated to be 1477-1722 cc per day. Review of intake and output records from 6/3/05 through 6/16/05 noted that the resident's intake was less than 1,000 cc on 6 of 11 days and only met the estimated fluid needs on one of 11 days. Review of the clinical record with the registered nurse on 6/16/05 at 2 PM failed to provide evidence that the physician was notified of the poor intakes.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-Dt8
(f) Administrator (3)(A).

2. Based on review of facility grievance documentation, and interviews with residents, families and staff, the facility failed to ensure that grievances reported by residents and/or their families, were investigated and/or that the residents/families received a response to their concerns from the facility. The findings include:
 - a. Multiple interviews with residents and family members identified that numerous complaints/concerns related to lack of nursing care of residents, poor responses to call bells, and physical plant issues had been brought to the attention of the administrator. Review of the facility grievance log failed to identify documentation of the specific grievances raised by the residents and/or families. The residents and families identified through interviews throughout the survey that the administrator failed to respond to their grievances and that the practices brought to her attention continued to be problems.

FACILITY: Maefair Health Care Center

DATES OF VISIT: June 13, 14, 15, 16, 17, 22, 23 and 27, 2005

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-Dt8
(f) Administrator (3) and/or (g) Reportable event (6).

3. Based on clinical record reviews, review of facility investigations, observations, review of the facility abuse prohibition policy and procedure and interviews for 7 of 10 sampled residents with injuries of unknown origin and/or allegations of mistreatment by staff (Resident #s 4, 6, 11, 40, 44, 45, 46), the facility failed to ensure that all allegations of abuse/neglect and/or injuries of unknown origin were thoroughly investigated and/or reported in accordance with the regulations or that residents were safeguarded while investigations were initiated in accordance with facility policy resulting in a finding of immediate jeopardy. The findings include:
 - a. Resident #6's diagnoses included falls, neuropathy and osteoarthritis. Nursing notes dated 5/2/05 identified discoloration of the left orbit. A physician progress note dated 5/3/05 noted left eyelid ecchymosis. Treatment of cool compresses was ordered for 5 days. Interview with the resident on 6/15/05 at 9:45 AM noted that at the time of the eye injury, the nurse aides were rough and gruff with her, and had rolled her over into the siderail. Review of the facility investigation with the Acting Director of Nursing on 6/16/05 at 2:00 PM failed to provide evidence that the allegation of mistreatment had been thoroughly investigated as evidenced by a lack of interviews with staff that cared for the resident during at least the 24 hours preceding the discovery of the injury or that the injury had been reported in accordance with the regulations and the facility abuse policy.
 - b. Resident #11's diagnoses included spinal stenosis and depression. A quarterly assessment dated 5/31/05 identified that the resident had no memory impairment. A psychiatric Advanced Practice Registered Nurse's (APRN) note dated 9/24/04 identified that the resident reported being verbally abused by a Nurse Aide (NA) earlier in the week. The note identified that the APRN spoke at length with the former administrator and director of nursing and that the administrator met with the resident. Interview with the resident on 6/16/05 at 1:10 PM identified that back in September, a nurse aide on the evening shift had been rude and impatient with her one evening. The resident stated that the following evening in the dining room, the nurse aide said to her "you think you're the queen around here, you are really something aren't you". The resident could not recall who the aide was or the date of the incident. Interview and review of the clinical record with the Corporate Nurse on 6/17/05 at 8:00 AM failed to provide evidence that the allegation by the resident had been investigated as evidenced by a lack of interviews with staff that cared for the resident during at least the 24 hours preceding the discovery of the

FACILITY: Maefair Health Care Center

DATES OF VISIT: June 13, 14, 15, 16, 17, 22, 23 and 27, 2005

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

incident or that the incident had been reported in accordance with the regulations and the facility abuse policy. Staff could find no evidence of follow up on the resident's complaint in the clinical record or reportable event files. The former Administrator was not available for interview.

- c. Resident #40's diagnoses included Parkinson's disease, psychosis and depression. The quarterly assessment dated 5/5/05 identified the resident was cognitively impaired, required extensive assistance with bed mobility, and was totally dependent on staff for transfers. The resident's plan of care (RCP) dated 5/16/05 identified the resident required total assistance with all activities of daily living, and the assistance of two staff members and a mechanical lift (Hoyer) for transfers.
 - i. Observations of the resident on 6/15/05 noted the resident to be out of bed in a tilt in space wheelchair and to have a green /blue color area around the left eye orbit. Facility documentation identified that on 6/12/05 at 4:30 PM, a Nurse Aide (NA) observed Resident #40 to have bruising around the left eye. Review of the reportable event documentation on 6/22/05 at 1:00 PM with the Corporate Nurse failed to provide evidence that the injury of unknown origin had been thoroughly investigated in accordance with facility policy to include written statements from staff assigned to the unit on all shifts for at least the 24 hours prior to the detection of the bruise.
 - ii. Facility documentation dated 5/30/05 identified that the resident was observed to have a skin tear to the left shin. Review of the facility investigation with the Corporate Nurse on 6/22/05 at 1:00 PM failed to provide evidence that the origin of the skin tear had been investigated appropriately as evidenced by a lack of interviews with staff that cared for the resident during at least the 24 hours preceding the discovery of the injury or that the injury had been reported in accordance with the regulations and the facility abuse policy.
- d. Resident #4's diagnoses included dementia, stroke and arthritis. A significant change assessment dated 3/14/05 identified the resident as cognitively impaired, and requiring extensive assistance with ADL's. Review of the nurse's notes dated 5/10/05 at 9:46 PM identified that the resident's right arm/elbow was observed to be swollen and the nurse aide reported that the resident appeared to be experiencing pain. An x-ray dated 5/11/05 revealed a deformity of the right humeral head with lateral displacement, which appeared to be chronic. During interview and review of the clinical record with the administrative staff on 6/16/05 at 3:10 PM, they were unable to provide evidence that the resident's swelling and apparent pain in the right arm had been reported or investigated by the facility as evidenced by a lack of interviews with staff that cared for the resident during at least the 24 hours

FACILITY: Maefair Health Care Center

Page 5 of 36

DATES OF VISIT: June 13, 14, 15, 16, 17, 22, 23 and 27, 2005

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

- preceding the discovery of the injury or that the injury had been reported in accordance with the regulations and the facility abuse policy. During interview and review of the nurse's notes on 6/16/05 at 4:30 PM with the Licensed Nurse who assessed the resident's right arm on 5/10/05, she reported that she was directed by the supervisor that reportable event documentation was not necessary.
- i. Facility reportable event documentation dated 5/25/05 identified the presence of a bruise on the left eye. Review of the facility investigation on 6/23/05 at 11:00 AM with the Corporate Nurse failed to provide evidence that a thorough investigation into the origin of the bruise had ever been completed as evidenced by a lack of interviews with staff that cared for the resident during at least the 24 hours preceding the discovery of the injury or that the injury had been reported in accordance with the regulations and the facility abuse policy.
 - e. Resident #44's quarterly assessment dated 3/15/05 identified that the resident was cognitively impaired, and dependent on staff for all activities of daily living including transfers and bed mobility. Facility documentation dated 4/6/05 at 9:00 AM noted bruising and swelling of the right knee, origin unknown. Review of the facility investigation on 6/23/05 at 11:00 AM with the Corporate Nurse failed to provide evidence that a thorough investigation into the origin of the bruise/swelling had ever been completed as evidenced by a lack of interviews with staff that cared for the resident during at least the 24 hours preceding the discovery of the injury or that the injury had been reported in accordance with the regulations and the facility abuse policy. Interviews on 6/23/05 with the nurse aides who cared for the resident during the shift the bruise was discovered and the preceding shift, discovered that both nurse aides had transferred the resident alone despite a physical therapy screen and care plan that directed that the resident be transferred with the assistance of two staff.
 - f. Resident #46's assessment dated 12/22/04 identified that the resident was cognitively impaired and totally dependent on staff for transfer, was resistant to care and had wandering behaviors. Facility documentation dated 2/2/05 identified the presence of bruising in the corner of the right eye. Interview and review of the facility investigation of the bruise with the Corporate Nurse on 6/23/05 at 11:00 AM failed to provide evidence that a complete investigation into the origin of the bruise had taken place including obtaining statements from staff who had cared for the resident for at least the previous 24 hours.
 - g. Resident #45 was admitted on 4/6/05 with diagnoses that included history of a stroke. The admission assessment dated 4/19/05 identified that the resident was without cognitive impairment and required assistance from staff for bed mobility

DATES OF VISIT: June 13, 14, 15, 16, 17, 22, 23 and 27, 2005

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

and transfers. Review of facility documentation dated 5/21/05 identified that the resident reported shoulder pain. Documentation dated 5/24/05 in the form of a memo from the social worker identified that the resident reported to her that an 11-7 nurse aide was mad at her because she needed help toileting and was rough with her, pulling at her arm. Interview and review of the documentation with the Corporate Nurse on 6/22/05 at 1:00 PM noted that administration did not initiate an investigation until 5/26/05 at which time reportable event documentation was initiated. Review of the records failed to provide evidence that an immediate and complete investigation into the resident's allegation had been completed as evidenced by a lack of interviews with staff that cared for the resident during at least the 24 hours preceding the discovery of the injury or that the injury had been reported in accordance with the regulations and the facility abuse policy as evidenced by a lack of interviews with staff that cared for the resident during at least the 24 hours preceding the discovery of the injury or that the injury had been reported in accordance with the regulations and the facility abuse policy, or that measures were taken to safeguard the residents while an investigation took place. Interview on 6/22/05 at 11:00 AM with the Acting Director of Nursing who had been responsible for monitoring reportable events, noted that injuries of unknown origin or allegations of rough handling were not being tracked for trending by unit, shift, or personnel involved. She was unaware that there had been at least 5 incidents of residents discovered with bruises of the eye area in the previous 3-4 months all on one floor. Further interview noted that she stopped investigating injuries further when she came up with a potential cause to the injury (even though the causes were not witnessed). When asked to review inservice education provided to staff on the prevention of injuries, transfer techniques, resident safety or abuse education, the facility was unable to provide evidence that the education had occurred. The Administrator responsible during the incidents cited above was no longer employed by the facility and unavailable for interview during the survey. Immediately prior to the surveyors informing the facility of the finding of immediate jeopardy, corporate staff located a file in the former administrator's office containing numerous "communication" (complaint/grievances) forms documenting complaints from residents and families of neglect or mistreatment by staff. Reportable event documentation or investigations were not available to correspond to several of the allegations of mistreatment reviewed by surveyors nor was there any evidence that investigations had occurred.

DATES OF VISIT: June 13, 14, 15, 16, 17, 22, 23 and 27, 2005

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-Dt8 (f) Administrator (3)(A) and/or (j) Director of Nurses (2).

4. Based on clinical record review, review of facility reportable event documentation and interviews for the only sampled resident that was witnessed being spoken to inappropriately (Resident #20), the facility failed to ensure that staff treated the resident with dignity and respect. The findings include:
 - a. Resident #20's diagnoses included Alzheimer's disease. A quarterly assessment dated 4/6/05 identified that the resident was moderately cognitively impaired and needed extensive assistance for eating. The care plan dated 4/14/05 identified a problem with decreased participation in activities of daily living. Interventions included that a nurse aide would assist the resident with eating. Facility documentation dated 6/3/05 identified nurse aide #18 was witnessed to use profanity directed at the resident. Sworn statements obtained by the surveyors from two witnesses, NA#21 and NA#27 confirmed that NA#18 was overheard to use profanity directed towards the resident. NA#18 was no longer employed by the facility.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-Dt8 (f) Administrator (3) and/or (s) Social Work (7).

5. Based on clinical record reviews and interviews for the only sampled resident with a room change (Resident #12) and for 1 of 5 sampled residents with allegations of mistreatment by staff (Resident #45), the facility failed to ensure that the room change was not detrimental to the resident's psychosocial well being and that the resident was monitored and assessed after the change for adjustment problems and/or that the resident was assessed for needs/problems after making an allegation of mistreatment. The findings include:
 - a. Resident #12's diagnoses included dementia. A significant change assessment dated November 24, 2004 identified the resident as cognitively impaired, wandering, independent for locomotion, required extensive assistance for transfers and required assistance for ambulation. The Resident Care Plan updated through 3/01/05 included wandering, impulsive behavior, and risk of injury/falls as problems. Interventions included to monitor for increased anxiety and agitation, remove from setting as needed, redirect and report all unsafe conditions and situations. On 2/12/05, the resident was found at the bottom of the stairs on the

FACILITY: Maefair Health Care Center

DATES OF VISIT: June 13, 14, 15, 16, 17, 22, 23 and 27, 2005

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

first landing from the exit door at the end of the hall and sustained a laceration/abrasion of the left hand. Review of the clinical record documented that after a fall on 1/18/05 in the bathroom, the resident was relocated from the third floor to the second floor to be in a room that was closer to the nurse's station and to facilitate better observation. After the relocation on 1/19/05, the nurse's notes documented frequent episodes of anxious behaviors, wandering without purpose, oblivious to needs and safety, aggressive and combative behaviors. Social service notes dated 1/19/05 documented the room change and reason. No further entries were present. A physician progress note dated 2/13/05 documented that the staff reported that the resident was very unhappy and often was observed crying. The note went on to say that staff felt that the resident would be better on the other floor where she would be in familiar surroundings with familiar staff. On 6/15/05 at 7:45 PM, during an interview with the nurse aide who cared for the resident on 2/12/05 evening shift, he reported that on the evening of the fall down the stairs, the resident had been upset, refusing to stay in bed, wandering in the wheelchair at a fast rate and had to be frequently redirected away from the exit door/stairwell. Although the social worker reported on 6/15/05 at 4:45 PM that she had visited the resident after the transfer, review of the clinical record failed to provide evidence that monitoring of the resident and adjustment to the new environment had been done.

- b. Resident #45 was admitted on 4/6/05 with diagnoses that included history of a stroke. The admission assessment dated 4/19/05 identified that the resident was without cognitive impairment and required assistance from staff for bed mobility and transfers. Review of facility documentation dated 5/21/05 identified that the resident reported shoulder pain. A memo dated 5/24/05 from the social worker identified that the resident reported to her that an 11-7 nurse aide was mad at her because she needed help toileting and was rough with her, pulling at her arm. Review of social service notes failed to provide evidence that the social worker assessed the resident's needs during or subsequent to the event/complaint. Interview on 6/27/05 at 12 PM with the social worker who took the resident's complaint noted that although she had reported the allegation to the acting director of nursing, she did not follow up with the resident or document an assessment in the clinical record.

FACILITY: Maefair Health Care Center

DATES OF VISIT: June 13, 14, 15, 16, 17, 22, 23 and 27, 2005

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-Dt8
(j) Director of Nurses (2) and/or (o) Medical Records (2)(I).

6. Based on clinical record review, observations and interview for 1 of 2 sampled residents observed to call out frequently for help (Resident #18), the facility failed to develop and/or initiate a care plan to address the resident's distress. The findings include:
 - a. Resident #18's diagnoses included dementia and a recent fractured hip. An assessment dated 4/24/05 identified that the resident was moderately cognitively impaired and required limited assistance with activities of daily living. Facility documentation dated 6/4/05 identified that the resident fell and sustained a fractured hip. A care plan dated 6/10/05 identified that the resident was non ambulatory and totally dependent on staff for activities of daily. Observations on 6/15/05 from 6:30 P.M. to 7:50 P.M. noted the resident to be seated in a wheelchair with a lap tray in front of the nurse's station. The resident was further observed to be restless, continuously calling out and moving the wheelchair short distances. Licensed staff and nurse aides were observed at the nurse's station. Observations during this time further noted that staff failed to respond to the resident's behavior. Interview with the charge nurse on 6/15/05 at 7:50 P.M. noted that the resident had been calling out every evening since fracturing her hip. Interview with the care plan coordinator on 6/17/05 at 11 A.M. identified that the resident was frustrated since declining to a dependent state. Review of the care plan failed to identify behavioral interventions to address the resident's restlessness and frustration with the change in ability to perform independent activities.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-Dt8
(j) Director of Nurses (2) and/or (o) Medical Records (2)(I).

7. Based on clinical record review, observations and interview for the only sampled resident with aggressive/assaultive behavior (Resident #24), the facility failed to review and revise the resident's care plan when the resident began displaying assaultive behaviors toward other residents. The findings include:
 - a. Resident #24's diagnoses included Alzheimer's disease and psychosis. An admission assessment dated 3/10/05 identified that the resident was cognitively impaired, received anti-psychotic medications, displayed wandering, physically abusive and inappropriate behaviors and was resistive to care. The care plan last

FACILITY: Maefair Health Care Center

Page 10 of 36

DATES OF VISIT: June 13, 14, 15, 16, 17, 22, 23 and 27 2005

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

updated on 12/16/04 identified the potential for anxiety/agitation at times. Interventions included administering medications as needed. Reportable event documentation identified that the resident struck, grabbed or slapped other residents on 3/6/05, 3/12/05 and 3/14/05. Review of the resident's care plan with the care plan coordinator failed to provide evidence that the care plan had been reviewed and revised to address specific interventions for the resident's assaultive behaviors.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-Dt8 (i) Director of Nurses (2).

8. Based on clinical record reviews and interviews for three sampled residents (Resident #s 14, 40, 42), the facility failed to ensure that the residents were assessed in accordance with professional standards of practice related to elevated blood sugars and/or assessments of skin abnormalities, and/or assessment of a swollen joint. The findings include:
 - a. Resident #42 was admitted on 6/11/05 with a diagnosis that included a fracture of the hip. A facility admission review/assessment dated 6/11/05 identified the resident as alert and oriented and required minimum assistance with activities of daily living. On 6/16/05 at 2:30pm, a family was heard to report to the licensed nurse that the resident was not feeling well and had a very dry mouth. He reported to the nurse that he was a diabetic and a long time ago R#42 was told that she also was a diabetic, but had not needed to take any medication for it. Being concerned, the family member reported that he brought his blood sugar monitor to the facility and checked R#42's blood sugar. He reported to the nurse that R#42's blood sugar was over 200. The licensed nurse reviewed the clinical record and reported to the family member that there was no diagnosis of diabetes on the record. The licensed nurse was observed to speak to the supervisor who was on the unit at the time and was overheard to say, "Wait til the doctor hears about this one". Nursing notes documented that a call was placed to the doctor. During an interview on 6/16/05 at 2:45pm, the resident reported to the surveyor that her mouth was very dry, she had been drinking a lot of water and urinating more than normally. She also reported that she had been taking vitamins for her diabetes, didn't have any problems with it and that her blood sugar had never been over 200. In addition the resident reported that the food was very good, especially the desserts. Interview and review of the clinical record with the evening nurse on 6/17/05 at 9:50am failed to provide evidence that any assessment had been done by the licensed nurse or the supervisor

FACILITY: Maefair Health Care Center

DATES OF VISIT: June 13, 14, 15, 16, 17, 22, 23 and 27, 2005

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

- and failed to demonstrate that the resident's blood sugar had been assessed. On 6/17/05 at 10:15 during an interview with the supervisor present on 6/16/05 at 2:30pm, she reported that she had been informed of the resident's blood sugar, had made a note in the computer, had placed a call to the physician, but did not assess, interview or see the resident prior to leaving the unit. According to the Illustrated Manual of Nursing Practice, Third Edition, 2002, the patient's health status is compared to the norm in order to determine if there is a deviation from the norm and the degree and direction of the deviation.
- b. Resident #14's diagnoses included congestive heart failure, asthma, arthritis and hyponatremia. Resident #14 received hydrocortisone 10 mg daily. An assessment dated 4/12/05 identified the resident was cognitively impaired, required extensive assistance for bed mobility and transfers and was unable to ambulate. Physician orders dated 4/21/05 directed the resident have daily skin checks. Nurse's notes at 3 p.m. on 5/12/05 identified the resident had a bruise on the right forearm. The clinical record lacked further assessments or descriptions of the area. The weekly body audit dated 5/12/05 at 9:40 p.m. failed to identify that the resident had any bruises. The care plan dated 5/12/05 identified the resident had an impairment in skin integrity as evidenced by purpura and a stage two pressure area on the coccyx. On 6/14/05, 6/15/05 and 6/17/05, Resident #14 was observed to wear one Geri sleeve on the right arm. The left upper arm was noted to have a 1 by .25 inch linear scabbed area surrounded by a circular reddened area measuring approximately 2.5 inches. A yellow/green colored area measuring approximately 2 inches was noted in the inner aspect of the resident's right posterior arm. Nurse's notes dated 6/12/05 identified a reddened intact area to the left upper arm measuring 1 by 1.5 cm. The physician was notified, the area was cleansed with normal saline and a dry protective dressing was applied. The clinical record lacked further assessments of the area. The charge nurse on 6/14/05 identified that because the area was scabbed it did not require a dressing and was unable to determine when the area had opened and/or had developed a scab. According to the Illustrated Manual of Nursing Practice, Third Edition, 2002, the patient's health status is compared to the norm in order to determine if there is a deviation from the norm and the degree and direction of the deviation.
- c. Resident #40's diagnoses included Parkinson's disease, psychosis and depression. The quarterly assessment dated 2/3/05 identified the resident cognitively impaired, required extensive assistance with bed mobility and had a history of falling. Resident #40 only sometimes was able to understand and/or be understood by others. The resident's plan of care (RCP) dated 5/16/05 identified the resident

FACILITY: Maefair Health Care Center

DATES OF VISIT: June 13, 14, 15, 16, 17, 22, 23 and 27, 2005

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

required total assistance with all activities of daily living including the assistance of two staff members and a mechanical lift (Hoyer) to transfer. Resident #40 had no functional range of motion limitations and/or loss of voluntary movement of the hand and arms. Nurse's notes dated 3/31/05 identified that the resident presented with pain and swelling of the left wrist. The physician saw the resident and an x-ray on 3/31/05 was negative for a fracture. Subsequent nurse's notes dated 4/1/05, 4/2/05, 4/3/05 and 4/4/05 identified the resident's left wrist continued to be swollen and/or red and/or warm to the touch however failed to provide documentation that a complete muscular skeletal assessment to include range of motion of the resident's left wrist had ever been completed. An interview and review of the clinical record with corporate nurse consultant on 6/17/05 failed to provide evidence that a comprehensive assessment of the resident's left wrist had been done. She identified that because the x-ray was negative, no further assessments were completed. According to Medical Surgical Nursing by LeMone and Burke, 1996, muscular/skeletal assessments should include inspection of joints for deformity, swelling and redness. Joints should be palpated for pain, tenderness, warmth and crepitus. Range of motion should be assessed.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-Dt8 (j) Director of Nurses (2) and/or (m) Nursing Staff (2)(A).

9. Based on clinical record reviews, observations and interviews for four sampled residents (Resident #s 12, 14, 18, 21), the facility failed to ensure that the resident's plan of care and/or physician orders were implemented related to daily skin assessments and/or application of protective devices and/or removal of restraints and/or staff response to resident's distress. The findings include:
 - a. Resident #12's diagnoses included dementia. A quarterly assessment dated 2/23/05 identified the resident as cognitively impaired and requiring extensive assistance with activities of daily living. The Resident Care Plan included wandering, impulsivity and risk of injury from falls as problems. Interventions included to utilize an alarmed, self-release seat belt in the wheelchair and to release/remove the seat belt during meals. On 6/14/05 at 11:30 AM, the resident was unable to self-release the seat belt upon request. On 6/14/05 and 6/16/05 the resident was observed throughout the noon meal seated in a wheelchair with the seat belt in place. A review of the nursing care card in the resident's room noted that the seat

DATES OF VISIT: June 13, 14, 15, 16, 17, 22, 23 and 27, 2005

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

- belt should be removed during meals. On 6/16/05 at 1:30 PM during interview and observation of the resident with the licensed nurse and the nurse aide, the nurse aide was unaware that the seat belt was to be removed during meals.
- b. Resident #14's diagnoses included congestive heart failure, asthma, arthritis and hyponatremia. Resident #14 received hydrocortisone 10 mg daily. An assessment dated 4/12/05 identified the resident was cognitively impaired, required extensive assistance for bed mobility and transfer, and was non-ambulatory. Physician orders dated 4/21/05 directed the resident have daily skin checks. Nurses notes at 3 p.m. on 5/12/05 identified the resident had bruise /ecchymosed area on the right forearm. The clinical record lack further assessments of the area. The weekly body audit dated 5/12/05 at 9:40 PM failed to identify that resident had eccymotic areas. The care plan dated 5/12/05 identified the resident had impairment in skin integrity as evidenced by purpura and a stage two pressure area on the coccyx. Interventions included the use of geri sleeves for protection. On 6/14/05, 6/15/05 and 6/17/05, Resident #14 was observed wearing only one Geri sleeve on the right arm. The left upper arm was noted to have a 1 by .25 inch linear scabbed area surrounded by a circular reddened area measuring approximately 2.5 inches. A yellow/green colored area measuring approximately 2 inches was noted in the inner aspect of the resident 's right posterior arm. Nurse 's notes dated 6/12/05 identified a reddened intact area to the left upper arm measuring 1 by 1.5 cm. The physician was notified, the area was cleansed with normal saline and a dry protective dressing was applied. The clinical record lacked further assessments of the area. The charge nurse on 6/14/05 identified that because the area was scabbed it did not require a dressing and was unable to determine when the area had opened and/or had developed a scab. Review of the clinical record failed to provide evidence that daily skin assessments were completed and/or completed accurately as directed by physician orders or that geri-sleeves were applied for protection to both arms.
- c. Resident #18's diagnoses included dementia. An assessment dated 1/24/05 identified that the resident was moderately cognitively impaired and independent with activities of daily living. A care plan dated 3/29/05 identified a potential for impairment of skin integrity. Interventions included to utilize geri-sleeves to both arms for protection. Observation on 6/13 on the 7-3 shift and 6/15/05 on the 3-11 shift noted that a geri-sleeve was on the right arm but not on the left arm. Interview with the 3-11 charged nurse on 6/15/05 at 7:30 P.M., identified that the resident should have had geri-sleeves to both arms.
- d. Resident #21's diagnoses included osteoporosis, dementia and weakness. An admission assessment dated 6/2/05 identified that the resident was cognitively

DATES OF VISIT: June 13, 14, 15, 16, 17, 22, 23 and 27, 2005

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

impaired, and required extensive assistance with activities of daily living and transfers. The current care plan identified an alteration in comfort. Interventions included encouraging rest periods, position for comfort and assess mood and behavior. Constant observations on 6/15/05 from 9:30 - 11:30 AM noted the resident seated in a wheelchair in front of the nurse's station or in the dining room repeatedly calling out loud for help. Staff were in the vicinity but did not respond to the resident's requests or provide any comfort measures/ repositioning during that time.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-Dt8
(j) Director of Nurses (2) and/or (m) Nursing Staff (2)(A).

10. Based on interviews, observations and a reviews of the clinical records for two residents who had vascular heel ulcers and/or were recently admitted to the facility (Resident #s 30 and 16), the facility failed to ensure that measures to promote healing of open wounds on the lower extremities were initiated and/or that medications were provided as directed on the resident 's plan of care. The finding included:
 - a. Resident #30's diagnoses included diabetes, peripheral vascular disease and dementia. The assessment dated 5/15/05 identified the resident was cognitively impaired, dependant on staff member for bed mobility and transfers, was non-ambulatory, had bilateral range of motion limitations and partial loss of voluntary movement to the arms, hands and legs, and had stage two pressure areas and his skin was desensitized to pain and/or pressure. Facility documentation dated 6/01/05 identified Resident #30 had a left heel ulcer with eschar measuring 3 cm by 2.2 cm .2 cm and a right heel blister. The plan of care (RCP) dated 6/08/05 identified the resident had a blister on the left heel. Interventions included repositioning every two hours, report changes in appearance and elevate heels. Resident #30 used a pressure reducing mattress and chair cushion. Resident #30 was out of bed daily to a wheel chair using a mechanical lift. Observation on 6/14/05 and 6/15/04 identified the resident to be out of bed to a recliner with his feet elevated and his heels in direct contact with the footrest. No pressure relieving devices were noted in the vicinity of the resident or on the resident's chair. On 6/08/05 the right heel was noted with a clear blister and a 2cm by 1cm area with black eschar. The left heel was 2.5 cm by 2 cm by .2cm in depth. The nurse caring for the resident on 6/16/05 stated that the resident's seating was changed from his custom wheel chair

FACILITY: Macfair Health Care Center

DATES OF VISIT: June 13, 14, 15, 16, 17, 22, 23 and 27, 2005

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

- to a recliner and although the heels should be kept elevated, it was not specifically addressed on the RCP and/or the nurse aide assignment sheet.
- b. Resident #16's diagnoses that included colitis, hydrocephalus status post shunt replacement, hypertension and depression. Resident #16 was admitted to the facility on 4/15/05 and admission physician orders dated 4/16/05 directed the resident receive Sertraline 50mg and lansoprazole 30mg daily, and Carveditol 12.5mg twice a day. A review of the medication administration record (MAR) and the clinical record failed to provide evidence that the resident received the above listed medications on 4/16/05. LPN #3 who cared for the resident on 4/16/05 identified that the medications were not available and were not administered on 4/16/05. She identified that a delay in the physician's verification of Resident #16's admission orders resulted in a delay in placing the pharmacy request form. She identified that on 4/17/05 and there after, Resident #16 received all medications as prescribed by the physician.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-Dt8 (j) Director of Nurses (2) and/or (o) Medical Records (2)(H).

11. Based on clinical record reviews, observations and interviews for 1 of 21 sampled residents who were dependent on staff for transfers (Resident #s 27 and 28), the facility failed to assess the resident's transfer technique for decline and/or failed to transfer the resident in a safe manner. The findings include:
- a. Resident #28's assessment dated 3/17/05 identified that the resident was severely cognitively impaired and totally dependent on staff for activities of daily living including transfer. A care plan dated 3/15/05 identified the need for total assistance with transfers. Interventions included transferring the resident with the assistance of two. Observation of the resident while being transferred from bed to wheelchair on 6/13/05 at 12:15 P.M. noted the nurse aides (2) applying a gait belt around the resident's waist. The nurse aides were then observed transferring the resident by grasping the resident under her arms and holding onto the gait belt. The resident was observed to be toe touching and unable to bear weight. Subsequent to surveyor inquiry, the resident was assessed by the physical therapist, who determined that the resident should be transferred with a Hoyer lift. Interview with the physical therapist on 6/16/06 at 11:15 A.M. identified that lifting a non-weight bearing resident under the arms could result in injury.

DATES OF VISIT: June 13, 14, 15, 16, 17, 22, 23 and 27, 2005

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

- b. Resident #27's assessment dated 4/24/05 identified that the resident was moderately cognitively impaired and totally dependent on staff for activities of daily living including transferring. A care plan dated 4/24/05 identified that the resident was dependent for transfers with interventions that included transferring the resident with the assistance of two. Observation of the resident on 6/14/05 at 11:35 A.M. noted the resident being transferred by nurse aides (2) from the recliner chair to the bed. The nurse aides were noted to hold the gait belt, which was around the resident's waist while holding the resident under the arms and picking her up. The resident's toes touched the floor but the resident was unable to bear weight. Subsequent to surveyor inquiry the resident was assessed by the physical therapist who determined that the resident should be transferred via Hoyer lift. Interview with the physical therapist on 6/16/05 identified that transferring a non-weight bearing resident by pivoting and holding her up under the arms could cause injury.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-Dt8 (j) Director of Nurses (2) and/or (m) Nursing Staff (2)(B).

- 12. Based on clinical record reviews, observations and interviews for 3 of 21 sampled residents who needed staff assistance with activities of daily living (Resident #s 5, 18 and 22), the facility failed to ensure that resident's received the appropriate assistance with grooming, dressing, toileting/incontinent care and/or repositioning. The findings include:
 - a. Resident #5's diagnoses included left frontal hemorrhage and right hemiparesis. An annual assessment dated 4/24/05 identified that the resident was cognitively impaired, totally dependent on staff for all activities of daily living (ADL's) and was incontinent of bowel and bladder. The current care plan directed to keep the resident clean and dry. Observations of incontinent care on 6/13/05 at 11 AM noted that after completing incontinent care, two nurse aides were observed to pull up the resident's pants, which were noticeably wet and stained with urine. Subsequent to surveyor inquiry, the resident's pants were changed.
 - b. Resident #18's diagnoses included dementia. An assessment dated 4/25/05 identified the resident as moderately cognitively impaired, and requiring supervision or assistance with personal hygiene. A care plan dated 6/9/05 identified that the resident had a self-care deficit with interventions that included assisting the resident with dressing and grooming. Observations of the resident on

DATES OF VISIT: June 13, 14, 15, 16, 17, 22, 23 and 27, 2005

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

- 6/13, 6/14, 6/15/05 noted the resident's hair in her face and her hair appearing uncombed and greasy. Interview with the nurse aide on 6/16/05 at 11:35 P.M. identified that the resident needed her hair combed frequently as the resident occasionally touches and pulls on her hair. Intermittent observations from 6/13-6/15/05 noted the resident touching and pulling on her hair but failed to observe staff combing the resident's hair. Observation of the resident's fingernails on 6/15/05 at 7:30 P.M., noted the fingernails were long and jagged. Interview with the nurse aide on 6/16/05 at 11:30 P.M. identified that the resident's nails should have been trimmed on shower day.
- c. Resident #22's diagnoses included dementia and urinary tract infections. A quarterly assessment dated 4/17/05 identified that the resident was cognitively impaired, required extensive assistance for all activities of daily living (ADL), and was incontinent of bowel and bladder. The care plan dated 4/24/05 identified incontinence as a problem with interventions that included to toilet and/or provide incontinent care every two hours and as needed. Physician orders dated 6/7/05 directed to turn and reposition the resident every two hours. Constant observation of the resident on 6/15/05 from 3 PM to 6:40 PM (3 hrs and 40 minutes) noted the resident in bed with the head of the bed up 70 degrees without the benefit of incontinent care or repositioning. The soaker pad was saturated and a dried urine ring was noted on the pad.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-Dt8
(j) Director of Nurses (2) and/or (m) Nursing Staff (2)(A) and/or (m) Nursing Staff (2)(B).

13. Based on clinical record reviews, observations and interviews for 5 of 15 sampled residents with a pressure sores (Resident #s3, 6, 13, 21 and 29), the facility failed to ensure that the residents were turned and repositioned/provided with incontinence checks at least every two hours and/or failed to provide wound care in a manner that prevents infections and/or failed to provide pressure reducing devices to the chair for resident's who are at risk for skin breakdown and /or failed to assess the wounds in accordance with standards of practice (at least weekly). The findings include:
- a. Resident #13's diagnoses included stroke with right hemiparesis. A quarterly assessment dated 5/27/05 identified the resident as without cognitive impairment, totally dependent for all activities of daily living and incontinent of bowel and bladder. The care plan dated 6/7/05 identified impaired skin integrity as a problem.

DATES OF VISIT: June 13, 14, 15, 16, 17, 22, 23 and 27, 2005

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

Interventions included to reposition every two hours and utilize barrier cream. Physician orders dated 6/7/05 directed the application of dressings to both the left and right buttocks. Pressure sore documentation identified that on 6/3/05 the resident had 3 small stage two open areas on the right buttock. Observation on 6/15/05 from 4 PM to 7:05 PM (3 hours and 5 minutes), noted the resident seated in a wheelchair with a seatbelt without the benefit of incontinent care or repositioning. Observation of incontinent care at 7:05 PM noted that the dressing to the right buttock was coming off and no dressing was present on the left buttock. The left buttock was noted to be very reddened. Interview with the registered nurse on 6/16/05 at 2:20 PM noted that the physician had ordered a dressing to protect the left buttock, which was a stage I pressure sore.

- b. Resident #29 was admitted to the facility on 6/2/05 with diagnoses that included left shoulder fracture, dementia, dehydration and osteoarthritis. A nursing admission assessment dated 6/2/05 identified that the resident required assistance for bed mobility and transfers, was a total feed, was unable to ambulate and had no pressure sores. The care plan dated 6/8/05 failed to identify the resident's risk for pressure sores or interventions to prevent their occurrence. The care plan identified that the resident required a Hoyer lift for transfers to a geri-chair. A nurse's note dated 6/13/05 at 7:12 PM identified the presence of a stage one pressure sore of the coccyx measuring 3 cm. Constant observation of the resident on 6/15/05 from 3 PM until 6:20 PM noted the resident seated in a geri-chair without the benefit of a pressure reducing cushion, repositioning or a check for incontinence. The resident was observed to put the call light on at 6:10 PM and inform the nurse that responded to the light that his "bottom was burning". Observation of the dressing change to the coccyx at approximately 6:30 PM noted that the area was very red and measured 3.5 by 4 cm.
- c. Resident #6's diagnoses included falls, neuropathy and osteoarthritis. The assessment dated 6/1/05 identified that the resident was cognitively impaired, dependent on staff for ADL's and had stage two and three pressure sores. The care plan dated 6/8/05 identified impaired skin integrity. Interventions included to reposition the resident every two hours and to keep the heels elevated off the bed. Observation on 6/13/05 noted that the resident's heels were resting on the mattress. Observation on 6/15/05 from 9:45 AM through 2 PM (4 hours and 15 minutes) noted the resident in her room seated in the wheelchair and complaining that her buttocks were hurting. The resident stated that she had asked to go back to bed, but staff told her she would have to wait until after lunch. The resident was assisted to bed at 2 PM. Continuous observation from 2:00 to 5 PM noted the resident in the

FACILITY: Maefair Health Care Center

TRIT A
Page 19 of 36

DATE OF VISIT: June 13, 14, 15, 16, 17, 22, 23 and 27, 2005

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

- same position (total 3 hours) and the right foot was not elevated off the mattress surface.
- d. Resident #21's diagnoses included dementia, osteoporosis and a pressure sore of the midback. An admission assessment dated 6/2/05 identified that the resident was cognitively impaired and required extensive assistance from staff for all activities of daily living. The care plan dated 6/7/05 identified the presence of a pressure sore. Interventions included to assess the skin condition, measure the area, and monitor healing. Interview and review of the clinical record with the treatment nurse on 6/17/05 at approximately 2:45 PM, failed to provide evidence that the wound had been assessed from 5/21/05 through 6/9/05 or from 6/9/05 through 6/17/05 at which time the wound and surrounding reddened areas were noted to have increased in size.
 - e. Resident #3's diagnoses included hip fracture, dementia, Parkinson's disease and depression. The admission assessment dated 5/10/05 identified that the resident was cognitively impaired, totally dependent on staff for all activities of daily living, incontinent of bowel, and had two stage two pressure sores. The care plan dated 6/7/05 identified the presence of stage 2 pressure sores of the coccyx and left hip and an unstageable area of the right heel. Observations of wound care on 6/15/05 noted that the nurse put on gloves and proceeded to touch contaminated items on the treatment cart and in the resident's room, including reaching into a pack of gauze sponges with the contaminated gloves. With the same gloves on, the nurse then washed the resident's left hip wound, and without changing gloves or washing hands, cleansed the resident's buttock wound/excoriation. With the same gloves, the nurse reached into the large bag of gauze sponges and removed some to dry the wounds. The same gauze was used to first dry the buttock area and then the left hip wound. The nurse was then observed to drop the new dressing onto the resident's bed, pick it up and place it on the wound. The nurse then took the bottle of saline and bag of gauze sponges that were contaminated and put them back in the treatment cart. Subsequent to surveyor inquiry, the contaminated items were thrown away and the dressing changed.

FACILITY: Maefair Health Care Center

Page 20 of 26

DATES OF VISIT: June 13, 14, 15, 16, 17, 22, 23 and 27, 2005

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-Dt8
(j) Director of Nurses (2) and/or (m) Nursing Staff (2)(B).

14. Based on clinical record reviews, observations and interviews for 2 of 14 sampled residents with incontinence (Resident #s20 and 24), the facility failed to provide incontinent care in a manner that prevents infection/contamination. The findings include:
 - a. Resident #20's diagnoses included Alzheimer's disease. A quarterly assessment dated 4/6/05 identified that the resident was severely cognitively impaired, required extensive assistance for activities of daily living and was incontinent of bowel and bladder. The care plan dated 4/14/05 identified incontinence as a problem. Interventions included to toilet and provide incontinent care every two hours and as needed and to assist with hygiene. Observations on 6/15/05 at 2:09 PM and 6:45 PM noted a nurse aide filled the bathroom sink with water and soaked the washcloths, which were used to complete bathing and incontinent care
 - b. Resident #24's diagnoses included Alzheimer's disease, psychosis, dementia, incontinence and osteoporosis. An admission assessment dated 4/14/05 identified that the resident was severely cognitively impaired, required extensive assistance from staff for all activities of daily living (ADL's), and was incontinent of bowel and bladder. The care plan dated 4/15/05 identified ADL deficits. Interventions included toileting and/or incontinent care every two hours. Observations on 6/16/05 at 11 AM noted the nurse aide (NA) placing the wet washcloth which was to be used for incontinent care, first on the sink in the bathroom and then on the lid of the garbage pail and proceeded to wash the resident's perineal area with the contaminated washcloth.

FACILITY: Maefair Health Care Center

DATES OF VISIT: June 13, 14, 15, 16, 17, 22, 23 and 27, 2005

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-Dt8 (v) Physical Plant (16)(D)(ii).

15. Based on observation and interview, the facility failed to ensure that hot water temperatures were maintained in a safe range in resident areas to prevent potential injuries. The findings include:
 - a. Observation of hot water temperatures on 6/15/05 between 11 AM and 12 PM identified temperatures ranging from 122.3 to 124.4 degrees in multiple resident rooms and areas on both resident care units. The supervisor was notified and adjustments made to the boiler. Repeat temperatures between 2:05 PM and 2:15 PM noted temperatures ranging from 121 to 123.6. Interview on 6/16/05 at 11:20 AM and review of facility records noted that although logs of water temperatures were kept, an electronic thermometer was not being used and resulted in lower temperatures.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-Dt8 (j) Director of Nurses (2) and/or (m) Nursing Staff (2)(C).

16. Based on clinical record reviews, observations, review of facility reportable event documentation and interviews for 12 of 16 sampled residents at risk for injuries due to wandering, falls, and/or fragile skin (Resident #s12, 14, 18, 19, 20, 26, 37, 39, 40, 41, 44 and 46), the facility failed to protect and/or supervise the residents and/or initiate interventions to prevent further injuries and/or failed to assess the resident's needs and develop a plan of care to prevent injuries. The findings include:
 - a. Resident #12's diagnoses included dementia. A significant change assessment dated November 24, 2004 identified the resident as cognitively impaired, wandering, independent for locomotion, required extensive assistance for transfers and required assistance for ambulation. The Resident Care Plan updated through 3/01/05 included wandering, impulsive behavior, and risk of injury/falls as problems. Interventions included to monitor for increased anxiety and agitation, remove from setting as needed, redirect and report all unsafe conditions and situations. On 2/12/05, the resident was found at the bottom of the stairs on the first landing from the exit door at the end of the hall and sustained a laceration/abrasion of the left hand. Review of the clinical record documented that after a fall on 1/18/05 in the bathroom, the resident was relocated from the third floor to the second floor to be in a room that was closer to the nurse's station and to

FACILITY: Maefair Health Care Center

EXHIBIT **A**
Page 22 of 36

DATES OF VISIT: June 13, 14, 15, 16, 17, 22, 23 and 27, 2005

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

facilitate better observation. After the relocation on 1/19/05, the nurse's notes documented increased episodes of anxious behaviors, wandering without purpose, oblivious to needs and safety, aggressive and combative behaviors. After the fall on 1/18/05, a Physical therapy screen included recommendations for an alarmed self-release seat belt, every 15 minute checks and the recommendation for a room change closer to the nurse's station. On 6/15/05 at 7:45 PM, during an interview with the nurse aide who cared for the resident on 2/12/05 evening shift, he reported that on the evening of the fall down the stairs, the resident had been upset, refusing to stay in bed, wandering in the wheelchair at a fast rate and had to be frequently redirected away from the exit door/stairwell. In addition, he reported that no alarm sounded at the time of the resident's exit through the door, but while working in a nearby room, he heard a click noise like the door closing, went to look and saw the resident on the landing at the bottom of the stairs. During an interview with the administrator on 6/15/05 at 2:30 pm, she reported that the facility no longer has a wanderguard system in place, as the elevator, all exit doors, and stairwells have a key pad and require a code to be punched in prior to opening. In addition she reported that there was a twenty- second delay after opening the door until the alarm was activated. The facility failed to provide evidence that the resident was monitored for behavioral changes after being relocated to a new unit with new staff, or that interventions were initiated when the resident demonstrated escalation in wandering and/or aggressive behaviors after the move and the evening of the fall, or that every 15 minute checks were initiated as per the physical therapy recommendations.

- b. Resident #18's diagnoses included dementia and a recent fractured arm of unknown origin. A quarterly assessment dated 1/24/05 identified that the resident was moderately cognitively impaired and independent with activities of daily living including transfers. An annual assessment dated 4/24/05 identified the need for a one person assist with transfers. On 5/4/05 facility documentation identified that the resident was found on the floor in the bathroom. Facility documentation dated 6/3/05 identified that the resident was found in her room with edema of the right frontal lobe and right shoulder. Facility documentation identified that on 6/4/05 the resident was found on the floor in the dining room after breakfast. The resident was transported to the hospital and diagnosed with a fractured hip. Interview with the care plan coordinator on 6/16/05 at 1:15 P.M. and review of the clinical record, identified that the resident from April to June 2005, frequently required supervision and assistance with transfers. Further review of the care plan identified interventions for the resident's mobility failed to identify that the resident required

DATES OF VISIT: June 13, 14, 15, 16, 17, 22, 23 and 27, 2005

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

- supervision and assistance with transfers. In addition, facility documentation (investigation) dated 6/4/05 described the resident, as having an unsteady gait, which the documentation stated, could have been the cause of the fall. Review of the clinical record and reportable event documentation failed to provide evidence that interventions to supervise the resident had been implemented when the resident's gait was noted to be unsteady or the resident was noted to require assistance with transfers resulting in multiple falls.
- c. Resident #19's diagnoses included dementia and osteoporosis. An annual assessment dated 5/31/05 identified the resident with short term memory problems, modified independence for decision making, was resistive to care, required extensive assistance with all activities of daily living and had sustained a fall with a fracture in the past 31 to 180 days. The care plan updated to 5/24/05 included impaired mobility, weakness and fatigue as problems. Interventions included to transfer and ambulate with the assist of two. Nurse's notes dated 6/05/05 identified bruising on the resident's right sternum and right breast with complaints of chest pain. Interview with the resident on 6/15/05 noted the resident reported that a nurse aide providing care tripped and fell on top of her. Review of the reportable event and investigation with the acting director of nursing on 6/22/05 at 12 noon identified that subsequent to investigating the incident, it was identified that a nurse aide answered the call light and found the resident with her legs hanging over the side of the bed. The nurse aide then attempted to get the resident up to the chair by lifting the resident under the arms (around the chest) and fell onto the resident. The DNS stated that the aide was new and was to be reeducated on appropriate transfer techniques. Interview with the nurse aide who attempted to transfer the resident on 6/15/05 at 2:45 PM noted that although she was afraid the resident was going to fall, she attempted to transfer the resident to the wheelchair by herself by lifting the resident around the midsection.
- d. Resident #37's diagnoses included congestive heart failure, diabetes, pernicious anemia, and lymphoma and received anticoagulant therapy. The admission history and physical dated 5/10/05 identified the resident had a history of frequently falls. The nursing admission assessment dated 5/10/05 noted the resident had no cognitive impairments and had moderately impaired vision. The resident's plan of care (RCP) dated 5/11/05 identified the resident had impaired physical mobility as evidence by unsteadiness. Interventions included keeping the resident's call light within reach. Physician orders dated 5/12/05 directed that the resident transfer and ambulate with moderate assistance of one staff. On 5/16/05 at 8 a.m., nurse's notes identified that Resident # 37 was ambulating independently with the rolling walker

DATES OF VISIT: June 13, 14, 15, 16, 17, 22, 23 and 27, 2005

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

and fell on a wet bathroom floor. Resident #37 stated that on 5/16/05 he used the call light to request assistance, however when no one responded timely, he attempted to return to his bedside chair unassisted. Resident #37 stated that because he did not see the puddle on the bathroom floor, he lost his footing and fell. Resident #37 had no apparent injuries and the RCP was revised to include reminders to the resident to be aware of his surroundings. A subsequent physician order dated 5/27/05 directed that Resident #37 could ambulate independently with a rolling walker. Nurse 's notes dated 6/01/05 at 12:15 p.m. noted Resident #37 was found prone on the floor of his room with oxygen tubing wrapped around the leg of his walker. Resident #37 had a laceration above the right eye, which required sutures, a skin tear to the right wrist and an abrasion to the left shin. Resident #37 stated that on 6/1/05 at noontime, he was returning from the bathroom and was not able to see the oxygen tubing protruding from under the end of his roommate 's bed. Resident #37 stated that the tubing got caught in the legs of his walker, causing him to fall face first on the floor. An interview with the R.N. identified that Resident #37 's roommate was in bed and had recently began oxygen treatment. The tubing was inadvertently was left lying on the floor in Resident #37 's pathway.

- e. Resident #41's diagnoses included Alzheimer 's disease. The assessment dated 3/5/05 identified the resident had short and long-term memory deficits and was severely impaired in daily decision-making. Resident #41 was non-ambulatory and required extensive assistance with transfers. The resident 's plan of care (RCP) dated 3/7/05 identified the resident had a history of falling and required the use of a "lap buddy " when out of bed to the wheel chair. Nurse's notes dated 3/14/05 at 6:56 a.m. identified that Resident #41 was discovered on the floor and was noted to have edema and bruising to the left forehead. The RN supervisor identified that on 3/14/05 at 6:52 a.m. Resident #41 was discovered in a lateral position on the floor adjacent to the nurse 's station. The RN supervisor further identified that the resident was out of bed to the wheelchair without the benefit of a lap buddy. The nurse aide (NA) caring Resident #41 on 3/14/05 stated on 6/20/05 that at the time of the fall, she was unable to locate the NA assignment sheet. She was unaware that Resident #41 required the use of a lap buddy while in the wheelchair and did not apply one on 3/14/05.
- f. Resident #39's diagnoses included arthritis and dementia. A quarterly assessment dated 5/9/05 identified that the resident was cognitively impaired and required assistance from staff for all activities of daily living. Resident #24's diagnoses included Alzheimer's disease and psychosis with combativeness. The assessment

FACILITY: Maefair Health Care Center

DATES OF VISIT: June 13, 14, 15, 16, 17, 22, 23 and 27, 2005

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

dated 3/10/05 identified that Resident #24 was severely cognitively impaired and displayed behaviors that included wandering, resistive to care, physically abusive and socially inappropriate. R#24's care plan dated 3/7/04 identified that the resident had a history of physically striking other residents. Interventions included to divert/redirect and notify the nurse for anxious or agitated behavior. Facility reportable event documentation identified that Resident #24 physically grabbed, slapped or struck other residents on 3/6/05, 3/12/05 and 3/14/05. On 3/12/05, Resident #24 grabbed Resident #39's wrist causing a skin tear and bleeding. Interview and review of the clinical record with the care plan coordinator on 6/27/05 at 11 AM failed to provide evidence that the resident was supervised and/or assessed for changes to the plan of care related to aggressive behaviors when her behavior began to escalate.

- g. Resident #14's diagnoses included congestive heart failure, asthma, and arthritis. Resident #14 received hydrocortisone 10 mg daily. An assessment dated 4/12/05 identified the resident was cognitively impaired, required extensive assistance for bed mobility and transfer, and was non-ambulatory. Facility documentation dated 5/11/05 identified an allegation that a staff member grabbed her arm causing her pain. Nurse's notes at 3 p.m. on 5/12/05 identified the resident had a bruise /ecchymoses on the right forearm. The RCP last updated 5/10/05 identified the resident had impairment in skin integrity as evidenced by purpura. Interventions included assessing the skin condition, noting changes, developing and maintaining a turning schedule, using a gentle approach when administering care and the application of Geri glove. Physician orders dated 4/21/05 included daily skin checks. Orders dated 5/13/05 identified the resident required two care givers for administering care. Observation of Resident #14 during morning care on 6/14/05 identified that one staff member administered care. Observations on 6/14/05, 6/15/05 and 6/17/05 identified the resident wearing a short sleeve dress with a Geri sleeve on the right arm only. The left upper arm was noted to have a one-inch linear scabbed area surrounded by a 2.5 circular discolored area. Facility documentation dated 6/12/05 identified a reddened area to the left upper arm measuring 1 by 1.5 cm. and lacked further assessments. The NA administering care on 6/14/05 was not aware that the resident had fragile skin and/or required the use of Geri sleeves and/or that two staff members were to administer care. A review of the nurse aide assignment sheet failed to identify that resident had fragile skin and /or failure to identify that two staff members were required care and/or the resident used Geri sleeves. An interview with the care plan co-coordinator identified that nurse aide assignment sheets were computer generated and kept at the bedside. Updates were

DATES OF VISIT: June 13, 14, 15, 16, 17, 22, 23 and 27, 2005

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

done quarterly and/or with each care plan conference. Due to time constraints, interim care plans were not always reflected in the nurse aide assignment sheets.

- h. Resident #40's diagnoses included Parkinson ' s disease, psychosis and depression. The quarterly assessment dated 5/5/05 identified the resident was cognitively impaired, required extensive assistance with bed mobility, and was totally dependent on staff for transfers. The resident ' s plan of care (RCP) dated 5/16/05 identified the resident required total assistance with all activities of daily living, and the assistance of two staff members and a mechanical lift (Hoyer) for transfers.
- i. Observations of the resident on 6/15/05 noted the resident to be out of bed in a tilt in space wheelchair and to have a green /blue color area around the left eye orbit. Facility documentation identified that on 6/12/05 at 4:30 p.m., a nurse aide (NA) observed Resident #40 to have bruising around the left eye. Review of the reportable event documentation identified that the resident was found with his face pressed into the siderail. Interview on 6/23/05 at 10:30 AM with the nurse aide who found and reported the bruise noted that the resident was not capable of turning himself in the bed without assistance. She further noted that when she checked on the resident and found the bruise, he was on his side close to the rail, but his face was not pressing on the siderail. Subsequent to the discovery of the bruise, the resident's care plan identified that side rail pads were to be utilized. Observation on 6/23/05 at 10:30 AM and interview with the nurse aide on duty, noted that the side rails pads were not available in the room and had not been utilized for the resident despite being identified as an intervention on the care card (assignment).
- ii. Facility documentation dated 5/30/05 identified that the resident was observed to have skin tear to the left shin. Review of the facility investigation identified that the skin tear was discovered when the resident's pants were removed. Interviews on 6/27/05 with the two nurse aides who transferred the resident the evening the skin tear was discovered noted that they had Hoyer transferred the resident into the bed for incontinent care before dinner. They did not notice a skin tear at that time. At approximately 8 PM, the nurse aides stated that they saw the skin tear prior to putting the resident to bed. Both nurse aides thought that the skin tear was from the resident's leg hanging over the leg rest on the custom wheelchair. Observation of the wheelchair on 6/27/05 at 1:30 PM noted that the resident could not get his legs through or around the leg rests if they were applied appropriately. Subsequent to the discovery of the skin tear, the resident's care plan identified that geri legs were to be utilized. Observation on 6/23/05 at 10:30 AM and interview with the nurse aide on

FACILITY: Maefair Health Care Center.

DATES OF VISIT: June 13, 14, 15, 16, 17, 22, 23 and 27, 2005

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

duty, noted that the side rails pads were not available in the room and had not been utilized for the resident despite being identified as an intervention on the care card (assignment) and that geri-legs were not being used for the resident's protection.

- i. Resident #20's diagnoses included Alzheimer's disease. A quarterly assessment dated 4/06/05 identified the resident as cognitively impaired, required extensive assistance with activities of daily living and had sustained falls in the previous 30 days and 31 to 180 days. The resident care plan dated 4/14/05 included falls as a problem with interventions that included to utilize a bed alarm. On 6/15/05 at 6:45pm the resident was observed in bed with the bed alarm placed under the covers, but not securely attached to the bed. An interview with the staff development nurse on 6/15/05 at 6:45pm noted that the alarm box needs to be secured to something stationary in order to activate and function when the resident gets up from the bed.
- j. Resident #26's assessment dated 4/26/05 identified that the resident was moderately cognitively impaired and totally dependent on staff for activities of daily living including turning and positioning (bed mobility). A care plan dated 4/26/05 identified that the resident was totally dependent on staff for transfers. Interventions included transferring the resident in and out of bed utilizing the Hoyer lift. Observations on 6/15/05 at 3:30 PM noted two nurse aides (NA) transferring the resident into bed from the wheelchair utilizing the Hoyer lift. As the aides were turning the Hoyer sling around to lower the resident into the bed, the resident's head was noted to touch the vertical bar. The resident was heard to say "oh my head" and held her hand on the back of her head. Interview with the charge nurse on 6/15/05 at 6:30 P.M. identified that the resident would have neurological assessments performed. She also stated that during a transfer with the Hoyer lift, body parts should not come in contact with the vertical bar.
- k. Resident #46's annual Minimum Data Set (MDS) dated 12/22/04 identified that the resident was cognitively impaired, had difficulty communicating needs, was totally dependent for bed mobility and transfer, resistant to care and utilized a mechanical lift for transfer. The care plan identified activities of daily living (ADL) self-care deficit. Interventions included transferring with a Hoyer lift with assistance of two. Nursing notes dated 2/2/05 noted the presence of a bruise/ecchymosis of the corner of the right eye at 8 AM. Review of other facility documentation noted that while administering medications at 8 AM, the resident was observed to have a bruise in corner of right eye. During interview on 6/27/05 at 10:55 AM with the licensed nurse on duty from 7 AM - 3 PM the day the bruise was discovered, she reported

DATES OF VISIT: June 13, 14, 15, 16, 17, 22, 23 and 27, 2005

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

the bruise about the "size of a nickel", appeared to be red/blue and "fairly new" (no yellowing component). In addition, she reported the resident did not seem to be in pain and was unable to answer questions regarding the bruise. She stated that the resident was out of bed in a wheelchair at the nursing station at 7 AM when she arrived at work. During interview on 6/27/05 at 10:30 AM with the nurse aide assigned on the 11 AM - 7 PM shift who had provided morning care, she reported that at approximately 6 AM, she provided morning care and with the assistance of the nurse, transferred the resident out of bed to a wheelchair without utilizing the mechanical lift. In addition, she reported that this was the usual way the resident was transferred each morning. She was unable to provide the name of the nurse that assisted with the transfer that morning.

- l. Resident #44's quarterly assessment dated 3/15/05 identified that the resident was cognitively impaired, displayed socially inappropriate behaviors, required extensive assistance for bed mobility and transfer and utilized full siderails as a restraint. The care plan dated 9/30/04 updated through 6/21/05 included diminished activities of daily living (ADL's). Interventions included providing total assistance with all ADL 's and to transfer with the assistance two for safety. A physical therapy screen dated 1/14/05 identified that the resident was unable to ambulate and required the assist of two staff for transfers. Review of nursing notes dated 4/6/05 at 10:25 PM noted the presence of right knee bruise with no complaint of pain and the medical director was updated. Review of other facility documentation noted that at 9 AM on 4/6/05 the resident was observed to have a bruise and swelling of the right knee. During interview with nurse aide who worked from 11 PM on 4/5 to 7 AM on 4/6/05, she reported that at 6:15 AM she provided morning care and transferred the resident to a recliner by herself. In addition, she reported that when she entered the room the resident's right leg was over the top of the siderail and resident had slid down to bottom of bed while attempting to get out of bed. She reported that at 6:15 AM, the resident's right knee was not bruised or swollen. The day shift nurse aide stated on 6/23/05 at 1:45 PM, that when she reported to work at 7 AM, the resident was already out of bed in a recliner chair at the nursing station. She further identified that at 9 AM, while toileting the resident by herself (without transfer assistance), the resident complained of pain in the right knee and bruising and swelling were identified at that time.
- m. Based on interview, and review of the clinical record, for one of twenty sampled residents (Resident#16) who were at risk for weight loss/altered nutrition, the facility failed to ensure that a weight loss was accurately communicated to the

DATES OF VISIT: June 13, 14, 15, 16, 17, 22, 23 and 27, 2005

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

dietitian and/or that interventions were instituted to prevent further weight loss.
The findings included:

- n. Resident #16's diagnoses included colitis, hydrocephalus status post shunt replacement, hypertension and depression. The assessment dated 4/22/05 identified the resident was cognitively impaired, required assistance from staff members for all activities of daily living except for eating and was non-ambulatory. Physician orders dated 4/16/05 directed the resident receive a no added salt, lactose restricted regular consistency diet, 60cc of the house supplement twice a day and was to be weighed weekly for four weeks. Nurse's notes dated 4/15/05 identified an admission weight of 140 lbs. Nurse's notes on 4/17/05 identified that Resident #16 complained of nausea was experiencing loose stools. From 4/17/05 through 4/20/05 the resident received a clear liquid diet, was medicated with Imodium and was tested negative for C-difficile. Although nurse's notes dated 4/20/05 identified the resident's weight to be 126.8 (below her ideal body weight), a nutritional risk assessment dated 4/22/05 identified that the resident weighed 140 lbs and noted the resident was within her ideal body weight range of 130 -158 pounds. Dietary notes further identified that the resident had no significant weight changes since her admission, however the resident was at risk for weight loss and dehydration due to her history of colitis. An interview with the dietitian (RDT) on 6/23/05 identified that the facility policy directed that residents be weighed within eight hours of admission and weekly for four weeks. Deviations in weights of 5 % were to be determined by nursing staff and the resident was to be reweighed. The re-weight was communicated to the dietitian via an e-mail system. The RDT stated that she was not aware of Resident #16's weight discrepancies on 4/22/05. She stated that her assessment on 4/22/05 was based on the nursing admission assessment weight of 140 lbs. A subsequent nutritional assessment dated 4/27/05 identified the resident's weight on 4/26/05 was 121 lb (a loss of 5.8.lbs). It was not until that point when the weight loss continued that the resident's dietary supplement was increased to 90 cc twice a day.

FACILITY: Maefair Health Care Center

EXHIBIT **A**
Page 30 of 36

DATES OF VISIT: June 13, 14, 15, 16, 17, 22, 23 and 27, 2005

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-Dt8
(i) Director of Nurses (2).

17. Based on clinical record reviews, observations and interviews for 5 of 7 sampled residents with diagnoses/history of dehydration (Resident #s 2, 3, 4, 16 and 29), the facility failed to ensure that interventions were initiated when the resident's intake failed to meet their estimated fluid needs and/or failed to assess for physical signs and symptoms of dehydration. The findings include:
 - a. Resident #16's diagnoses included colitis, hydrocephalus status post shunt replacement, hypertension and depression. The assessment dated 4/22/05 identified that the resident was cognitively impaired, required assistance from staff members for all activities of daily living except for eating, was non-ambulatory and was frequently incontinent of bowel and bladder. Although on 4/16/05 Resident #16's BUN was 35 (normal 7.0-18.0 mg/dl), the nursing admission assessment dated 4/16/05 identified the resident was at low risk for developing dehydration. The resident's plan of care (RCP) dated 4/16/05 identified the resident had an excess in fluid volume and included interventions to elevate edematous extremities and to restrict fluids. Resident #16's physician orders dated 4/15/05 directed monitoring the resident's intake and output; however from 4/17/05 through 4/19/05 the clinical record failed to identify that the resident's intake was monitored. The dietary assessment dated 4/22/05 identified the resident had a fluid intake of 63% of her estimated fluid requirements of 1600cc to 1920cc in twenty four hours and was identified to be at risk for dehydration due to her history of colitis and elevated BUN. The notes identified that fluids may need to be encouraged. The RCP was updated on 4/22/05 and identified the resident was a nutritional risk. Fluids were to be encouraged and the resident was to be monitored for signs and symptom of dehydration. From 4/17/05 through 4/25/05 although the resident was noted to have diarrhea, and the fluid intake fell below her estimated fluid needs (940cc to 1470cc), the clinical record failed to provide evidence that additional measures were enacted to prevent the resident from becoming dehydrated or that physical assessments for signs and symptoms of dehydration had been done. On 4/27/05, Resident #16 was admitted to the hospital with diagnoses of chronic colitis, diarrhea and dehydration. Review of hospital records identified a BUN on admission of 48. Review of the facility policy on dehydration with the corporate nurse on 6/27/05 identified that the policy failed to direct nursing staff to notify the resident's physician of poor intakes until such time as the resident showed actual physical symptoms of dehydration.

FACILITY: Fairfield Health Care Center

Page 31 of 36

DATES OF VISIT: June 14, 15, 16, 17, 22, 23 and 27, 2005

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

- b. Resident #3's diagnoses included urinary tract infections (UTI), dementia, and neurogenic bladder. An annual assessment dated 5/10/05 identified that the resident had moderately impaired cognitive status, required extensive assistance from staff for all activities of daily living (ADL) and had an indwelling catheter. The care plan dated 5/13/05 identified a problem with urinary retention with the potential for UTI. Interventions included to monitor intake and output. Review of the clinical record, identified that the resident had a hospital admission on 4/22/05 for dehydration and urosepsis. On 6/16/05, interview and record review of the clinical record with the dietitian identified that Resident #3's fluid needs for adequate hydration were estimated to be approximately 1800 cc 's daily. Review of nurse 's notes and intake and output records dated 3/29/05 through 4/29/05 noted that Resident #3 failed to ever meet the goal of 1800 cc 's for fluids hydration on a daily basis. In addition, the resident's output exceeded intakes on 13 days and for 7 days, intake and output recording was incomplete. Further review failed to provide evidence that a physical assessment for signs of dehydration had been completed or that a care plan had been developed to address the resident's potential for dehydration.
- c. Resident #2's diagnoses included dementia. A quarterly significant change assessment dated 12/22/04 identified that the resident was moderately cognitively impaired, required supervision for transfer and ambulation and was independent for eating. The care plan dated 12/22/04 identified a problem of potential for weight loss. The care plan failed to address the resident's calculated fluid needs. Interventions included diet as ordered, intake and output monitoring, dehydration assessments per policy, and to encourage fluids. The dietitian's assessment dated 7/5/04 was 1,327 to 1,592. An APRN progress note dated 3/9/05 noted that the resident was experiencing bronchitis and mild dehydration. Labs dated 3/10/05 identified that the resident 's BUN was 68, (normal 7-18). Physician orders dated 3/15/05 directed that IV therapy for hydration be started. The nurse's notes documented that the resident's fluid intake from 3/9/05 through 3/15/05 (7 days) was consistently well below estimated needs ranging between 600 - 1020cc. Nurse's notes 3/10 through 3/15/05 noted decreased mobility and a non-productive cough. On 3/14/05, the resident experienced dizziness, weakness and was unsteady. On 3/15/05, the resident was very weak, and refusing fluids. The physician's office was called at 3:05 PM. At 11:57 PM the physician returned the call and ordered IV therapy. Subsequent to IV hydration, a lab report dated 3/17/05 noted the BUN down to 26. Interview and review of the clinical record on 6/16/05 at 12:00 and 3:00 PM and 6/17/05 at 7:45 AM with licensed staff and

DATES OF VISIT: June 13, 14, 15, 16, 17, 22, 23 and 27, 2005

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

- administrative staff noted that resident's fluid intake was well below her estimated needs. Further interview failed to provide evidence that the resident's estimated fluid needs were met, that the resident was assessed for signs and symptoms of dehydration or that interventions to prevent dehydration were initiated.
- d. Resident #4's diagnoses included Alzheimer's disease, macular degeneration, congestive heart failure and history of a cerebral vascular accident. A quarterly assessment dated 12/13/04 identified that the resident was moderately cognitively impaired, required extensive assistance for activities of daily living, needed to be fed and had experienced a significant weight loss. The care plan dated 12/17/04 identified a risk for weight loss. Interventions included to assist with feeding, encourage intake, and monitor intake. The care plan failed to identify a risk for dehydration and approaches to prevent it. Nurse aide flow computer notes dated 2/18/05 through 2/23/05 identified that the resident consumed between 26 and 76% of fluids at 13 of 17 meal opportunities and no documentation of fluid intake was noted on 4 of 17 occasions. A lab report dated 2/23/05 noted that the resident's BUN was 74 (7-18) Creatinine 2.9 (0.7 to 1.5). Physician orders dated 2/23/05 directed that the resident be sent to the hospital for IV hydration. A lab report dated 3/3/05 after IV hydration, noted a BUN of 29 Creatinine 1.3 dated 3/3/05. Interview and review of the clinical record on 6/16/05 at 11:05 AM with the staff development nurse noted that the resident's intake and output had not been monitored until 2/22/05 when fluid intake was 240 cc and on 2/23/05 was 720cc. Review of the dietary notes on 6/17/05 at 11:45 with the dietician failed to provide evidence that an estimate of the resident's fluid needs had been calculated and documented in the clinical record. Interview noted that calorie needs and fluid needs are calculated the same and therefore, the resident would need approximately 1400 - 1820 cc/day. Interview and review of the clinical record on 6/16/05 at 11:15 AM and 6/17/05 at 7:45 AM with staff development and corporate staff, failed to provide evidence that a dehydration risk assessment had been done, and/or measures to increase fluid needs, identify fluid needs and/or assess for dehydration were identified.
- e. Resident #29 was admitted to the facility on 6/2/05 with diagnoses that included left shoulder fracture, dementia, dehydration and osteoarthritis. The hospital discharge summary of 6/2/05 identified that the resident had been admitted to the hospital from a different nursing home with "profound dehydration". A nursing admission assessment dated 6/2/05 identified that the resident required assistance for bed mobility and transfers, and was a total feed. The care plan dated 6/8/05 identified the potential for dehydration. The only intervention specific to

DATES OF VISIT: June 13, 14, 15, 16, 17, 22, 23 and 27, 2005

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

dehydration was to monitor signs and symptoms of dehydration. The resident's weight was noted as 130 pounds and fluid requirements were 1477-1722 cc per day. Review of intake and output records from 6/3/05 through 5/16/05 noted that the resident's intake was less than 1,000 cc on 6 of 11 days and only met the estimated fluid needs on one of 11 days. Subsequent to surveyor inquiry, a dehydration assessment was completed and documented, however, the assessment did not include any physical assessment of the resident. Review of the clinical record with the registered nurse on 6/16/05 at 2 PM failed to provide evidence that the physician was notified of the poor intakes that the care plan had been updated with interventions to prevent dehydration, or that physical assessments for signs and symptoms of dehydration had been performed.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D&u Intravenous Therapy (c)(1)(C)(iv).

18. Based on review of intravenous therapy (IV) records, clinical records and interviews, the facility failed to ensure that resident's receiving IV therapy were entered into the IV log and/or for the only sampled resident receiving IV therapy (Resident #33), that the solution and tubing were labeled and dated in accordance with standards of practice. The findings include:
 - a. Review of the IV therapy program with the corporate nurse on 6/14/05 at 11 AM failed to provide evidence that resident's receiving IV therapy had been entered into the log from 3/31/05 through June 4, 2005.
 - b. During tour of the facility on 6/13/05 at 11:40 AM, Resident #33's IV bag and tubing were noted to be lacking appropriate dating and labeling. Interview with the charge nurse at that time noted that she had hung the bag and should have labeled it.

DATES OF VISIT: June 13, 14, 15, 16, 17, 22, 23 and 27, 2005

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

floor, holding the soiled linen next to her uniform and walking out to the soiled linen bins in the hallway. In addition, the nurse aide was noted separating the soiled linen in the hallway and placing the linen in individual bins. Interview with the nurse aide on 6/15/05 at 8P.M. identified that she should not place the linen on the floor. Interview with the corporate nurse on 6/16/05 at 10 A.M. identified that the soiled linen should be bagged at the bedside and not sorted in the hallway.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-Dt8 (n) Medical and Professional Services (1).

21. Based on clinical record review, the facility failed to ensure that the resident's attending physician visited the resident and completed a history and physical within 48 hours of admission to the facility. The findings include:
 - a. Resident #29 was admitted to the facility on 6/2/05 with diagnoses that included left shoulder fracture, dementia, dehydration and osteoarthritis. Review of the clinical record with the registered nurse on 6/16/05 at 11 AM failed to provide evidence that the attending physician had visited/assessed the resident prior to 6/12/05 (10 days) or that a history and physical had ever been completed.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-Dt8 (j) Director of Nurses (2) and/or (o) Medical Records (2).

22. Based on interview and review of the clinical record for one resident (Resident #40) who was a nutritional risk, the facility failed to ensure that the clinical record was complete and accurate.
 - a. Resident #40 had diagnoses of Parkinson ' s disease, psychosis and depression disorders. The quarterly assessment dated 5/5/05 identified the resident had short and long-term memory deficits and was moderately impaired in making daily decisions. Resident #40 required supervision with meals. The resident ' s plan of care (RCP) dated 5/16/05 identified the resident was at risk for aspiration and required liquids thickened to pudding consistency. The resident was to be observed during meals and his weight to be monitored as directed by the physician. Dietary notes dated 2/02/05 identified a significant weight loss of 10 % in 180 days.

DATES OF VISIT: June 13, 15, 16, 17, 22, 23 and 27, 2005

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-Dt8
(j) Director of Nurses (2) and/or (t) Infection Control (2).

19. Based on review of the infection control program, policies and procedures, and interview, the facility failed to maintain an adequate infection control program in accordance with facility policies in relation to maintaining line listings of resident's with a history of resistive bacterial infections and/or making routine monthly environmental rounds. The findings include:
 - a. Review of the infection control documentation failed to provide evidence that a current line listing of all residents with a history of methicillin resistant staphylococcus aureus (MRSA), Vancomycin Resistant Enterococcus (VRE) and clostridium difficile (C-diff) had been maintained by the infection control nurse. Interview and review of the facility policies with the corporate nurse on 6/14/05 at 11 AM noted that the infection control nurse was no longer employed and that she was unable to locate any line listings as required by facility policy.
 - b. Requests to view environmental rounds as a result of multiple family complaints regarding the cleanliness of the facility prior to survey were unable to be met by the facility. Interview with the corporate nurse on 6/14/05 at 11 AM noted that the infection control nurse was no longer employed and that she was unable to locate any evidence of environmental rounds as required by facility policy.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-Dt8
(j) Director of Nurses (2) and/or (t) Infection Control (2).

20. Based on clinical record reviews, observations and interviews, the facility failed to ensure that linen was handled in a manner that prevents transmission of infections. The findings include:
 - a. Resident #26's assessment dated 4/26/05 identified the resident as moderately cognitively impaired, incontinent and totally dependent on staff for activities of daily living. A care plan dated 4/26/05 identified an alteration of bowel and bladder functioning. Interventions included to provide incontinent care every two hours. Observation of the resident being provided with incontinent care on 6/15/05 at 4 P.M. noted the resident to be incontinent of urine. After the nurse aide removed the diaper and incontinent pad she placed the soiled linen on the floor. Upon leaving the room the nurse aide proceeded to pick up the linen off of the

DATES OF VISIT: June 13, 14, 15, 16, 17, 22, 23 and 27, 2005

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

(weight on 1/24/05 was 102 lbs.) Subsequent dietary notes dated 5/05/05 identified a significant weight gain (weight on 5/2/05 was 111 lbs.). Notes of 5/11/05 identified that the resident's actual weight was 98.6 lbs., which did not reflect a significant weight gain.

FLIS Independent Nurse Consultant Guidelines

Relationship between Independent Nurse Consultant (INC) and DPH includes:

- An INC is utilized as a component of DPH's regulatory remedy process. An INC may be agreed upon as a part of a Consent Order between the institution and the Department when significant care and service issues are identified.
- The INC has a fiduciary or special relationship of trust, confidence and responsibility with the Department.
- The INC's responsibilities include:
 - Reporting to the Department issues and concerns regarding quality of care and services being provided by the institution.
 - Monitoring the institution's plan of correction to rectify deficiencies and violations of federal/state laws and regulations. Reports to Department positive and negative issues related to said oversight.
 - Assessing administration's ability to manage and the care/services being provided by staff.
 - Weekly reporting to the Department of issues identified, plans to address noncompliance and remediation efforts of the institution.

Relationship between INC and the Institution:

- The INC maintains a professional and objective relationship with the institutional staff. The INC is a consultant, not an employee of the institution. The INC exercises independent judgment and initiative to determine how to fully address and complete her/his responsibilities. The institution does not direct or supervise the INC but must cooperate with and respond to requests of the INC related to her fulfilling her/his duties.
- The INC's responsibilities include:
 - Assessment of staff in carrying out their roles of administration, supervision and education.
 - Assessment of institution's compliance with federal/state laws and regulations.
 - Recommendations to institutional administration regarding staff performance.
 - Monitoring of care/services being provided.
 - Assists staff with plans of action to enhance care and services within the institution.
 - Recommendation of staff changes based on observations and regulatory issues.
 - Weekly reports to the institution re: assessments, issues identified, and monitoring of plans of correction.
 - Promotes staff growth and accountability.
 - May present some inservices but primary function is to develop facility resources to function independently.
 - Educates staff regarding federal/state laws and regulations.